

during the fifth and sixth decades, among men leading a normal sexual life, I should not go so far as Doctor Hatch and compare it to gray hair. In a personal communication, the late Dr. J. T. Geraghty made the statement that, in his experience, simple prostatic hypertrophy was unknown among men who had abstained from sexual intercourse, but that celibacy was no bar to cancer of the prostate. That corresponds with my experience.

The indications for operation are about the same as those usually mentioned, and will depend upon the whole picture rather than on any one symptom. The cystoscope, when it can be used, is a great help in diagnosis and in deciding upon treatment.

I think most operators are agreed that some cases are safe risks operated without a preliminary cystostomy. The blood chemistry seems to be of even greater importance in determining these cases than is the P. S. P. test. Local anesthesia is becoming more generally used, and the combination of sacral and para-sacral, together with cutaneous infiltration, gives brilliant results. However, I cannot agree that the routine use of epinephrin in the solution adds to the safety of the procedure.

Doctor Hatch's emphasis on dehydration is a good point. The tendency on the part of the nurse is to neglect the fluid intake. The operator must closely check the urinary output, particularly during the first three days after operation.

JAMES R. DILLON, M. D. (516 Sutter Street, San Francisco)—Doctor Hatch has very well covered the more important points regarding pathology, symptomatology, and preparation for prostatectomy.

The prognosis of the prostatic patient is proportional to the best management, just as the successful result is proportionate to the accurate diagnosis of the pathological condition present. Refinements in diagnosis and treatment have reduced the mortality and morbidity on this basis to a minimum, and further advance must lie in the education and conviction of the general practitioner and layman that the patient should seek earlier surgical treatment and not be allowed to drift into a dangerous condition beyond surgical aid by the use of urinary antiseptics and bladder drainage by catheter. Next important to establishing the functional stability of the kidneys in the preparation of the prostatic patient is the study of the cardio-vascular system. Myocarditis, often secondary to damaged kidneys and a forerunner of uremia, is a dangerous contra-indication to prostatectomy under general anesthesia. In these circumstances it should be done under spinal or para-sacral anesthesia, after thorough preliminary preparation of the heart and kidneys.

Regarding the choice of operative technique, we find 65 per cent of prostatic patients are excellent risks, and, if carefully prepared, have good surgery and are properly managed post-operatively, should recover, no matter whether suprapubic or perineal routes are used. With the 20 to 35 per cent of poor risks, it is better to do the perineal prostatectomy under gas and oxygen or spinal anesthesia, and get those decrepit old men about in a few days to avoid pulmonary, cardiac, and renal complications. The punch operation should be reserved for fibrotic contractures of the vesical orifice, or median bar obstruction, as hypertrophy of Albarrans' glands, and is usually indicated in the fourth decade of a man's life. After the age of 50 the fibrosis has extended through the prostate, obstructing the whole of the prostatic urethra, and nothing short of a prostatectomy will give complete relief.

Suggesting a Revival of Medical Apprenticeships—

"The old system of medical apprenticeship had many things to commend it, but it is out of date and cannot be adjusted to the needs of the times," according to E. H. Ochsner (American Medicine). "There is, however, a real need for a system of apprenticeship and junior partnership which only the organized medical profession as a whole can work out and make operative. Such a system should utilize the vast practical experience and ripe judgment of the older members of the profession and the better technical training of the men just entering the profession and could be made equally advantageous to both, as well as the public in general."

COEXISTING LARGE FIBROID AND PREGNANCY—CAESAREAN SECTION AND HYSTERECTOMY AT TERM.

REPORT OF A CASE

By C. A. DeLANCEY, M. D., *San Anselmo, Calif.*

This rather unusual case record is published, not only because it has interesting features, but particularly because of the "wild" stories about it published in some newspapers, and its treatment in the alleged "humor column" of a medical journal.—EDITOR.

MRS. X presented herself for examination because of digestive disturbances of two weeks' duration. She complained of nausea and distress at sight of food, particularly in the morning.

Further history revealed that she had missed her last menstrual period on March 4, 1924, although she had previously menstruated normally. She gave her age as 42, had been married ten years and had had no previous pregnancies.

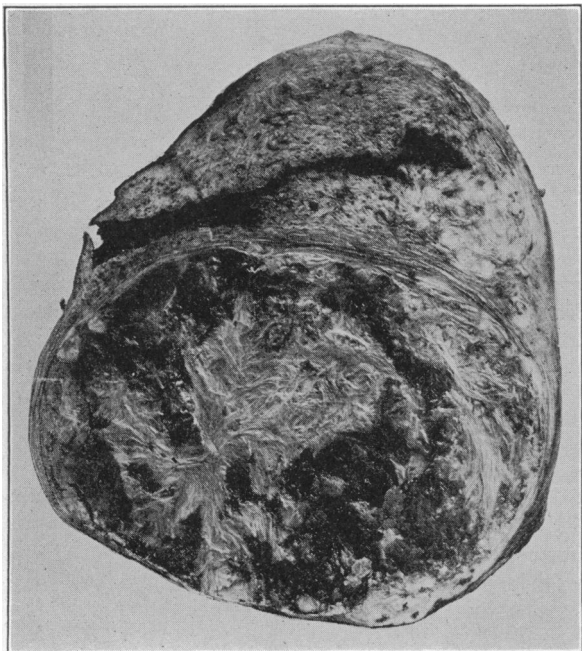
Physical examination was negative except that a large solid tumor mass extending from within the pelvis to the umbilicus was outlined. It was about the size of a six months' pregnant uterus. Questioning revealed that this mass had been diagnosed four years previously as a fibroid tumor by physicians who had advised operation. The patient, because of her desire for offspring, had refused surgical intervention.

On September 3, 1924, the patient called again, stating that she had not menstruated since March and thought she had felt life in her abdomen in July. Examination at this time revealed a soft cervix, bluish external genitals and the mass greatly increased in size, and of soft consistency. The solid mass was felt to the right and lower part of the abdomen, while to the left and lower the mass was softer. Auscultation revealed a uterine souffle and foetal heart sounds in the lower left quadrant. A diagnosis of a five months' pregnancy, complicated by a fibroid, was made at this time.

The patient's period of gestation was uneventful except for a slight nausea which she complained of during the early months. As the tumor rendered a normal delivery impossible, it was decided to perform a Caesarian section *at term*.

On December 8, the patient was admitted to the hospital and on the following day the operation was performed. A left rectus incision was made and the uterus exposed. This was incised over its thinnest portion and a normal seven-pound girl delivered. The large tumor mass, together with the uterus with which it was intimately incorporated, was removed. The accompanying picture shows the specimen.

Dr. F. E. Blaisdell, who examined the specimen, reports it as a post-partum uterus, measuring 18 cm. in length, 19.5 cm. in width, and 10 cm. in antero-posterior diameter. Anterior surface presents a Caesarian incision sinistral to center, which measures 9 cm. in length. On posterior surface, likewise, sinistral in position is seen a circumscribed tumor measuring 3 x 4 x 4.8 cm.; it projects 1.5 cm. above the surface. Midfrontal section of uterus shows a large



Post-partum uterus with Caesarean scar and large fibroid.

oval solid elastic well-described tumor measuring 12.5 x 18.5 cm. in diameters. It is intramural in position, as its outer surface is invested by a thin, compressed layer of uterine tissue, and the serosa and subserosa is distinctly recognizable external to it. The tumor is in the right uterine wall. The uterine cavity is 11 cm. in length. The left uterine wall is 7.5 cm. in thickness. Cut surface of tumor shows pearly white strands of tissue running and intertwining in all directions; in scattered or continuous areas a large amount of mucinous substance is found. The tumor cut with marked resistance. The smaller tumor shows a similar structure, except that it is subserous and contains no mucinous material, and is entirely independent of the larger one. Microscopical examination of frozen sections mounted in balsam shows: The general histological characteristics of a fibroid. Scattered through the tissue are seen groups of epithelial cells arranged in the form of glands. There is mucinous softening, and spaces varying in size are filled with the mucinous material (gelatinous after fixation). No mitotic figures have been seen. In small areas near surface, groups of round cells and leucocytes are seen. Tumors are well-defined and apparently benign. Diagnosis: Adeno-fibro-myoma (intramural). Small fibromyoms (subserous).

The interesting features of the case are the normal, full-term development of the fetus in a fibroid uterus: Patient ten years married without previous pregnancy; conception at the age of 42; excellent recovery of both mother and child, following Caesarean and hysterectomy; absence of hemorrhage during gestation; justification for hysterectomy at the age of 42; complete preponderance of fibroid over uterus.

TREATMENT OF FRACTURE OF THE NECK OF THE FEMUR

By ETHAN H. SMITH, M. D., *San Francisco*

I SHALL not go into any unnecessary description of the hip-joint, or the various methods of treating the above-mentioned fracture. One method alone will suffice for nearly all cases, if properly applied.

As soon as I mention the method, I can hear many of my confreres say, "That is old." The main features of the method are old. So is the discovery of the circulation of blood. So also is the sunshine old, but it is still good.

Weight and pulleys in the straight position, with sand bags of the proper dimensions, properly applied, give ideal results, which are unequaled or unexcelled by any other method.

This method can be applied by a doctor all alone, anywhere that he happens to come to a patient, if necessity compels. Of course, the ideal place is to have the patient in a modern hospital. I would not think of treating a patient elsewhere, unless positively obliged to do so by force of circumstances.

The bed should have some thin boards placed under the mattress and over the springs from the level of the patient's shoulder blades to the feet. These boards should not impinge on the side rails of the bed, and should cover the springs only. The boards off an orange-box would do admirably. An anesthetic is never necessary. This fracture can be properly reduced and dressed without any unreasonable pain to the patient. Anesthetics cause a large number of fatalities in elderly people. If there were no other reason to recommend this method above all others, the avoidance of an anesthetic is ample reason why it is better than any other method.

The lower extremity is put in a straight position. A good quality of real moleskin plaster must be used.

Use two thicknesses of plaster. Have the strips five to six inches wide at the top, tapering down to three inches at the foot. Notch the margins of the plaster so that it will fit without wrinkles over the thigh, knee, and leg. Bandage the foot *always*. Use flannelette bandages, two and one-half inches wide and six yards long. After applying the plaster, be sure that it projects below the foot fully five inches. Make two holes in each lower end of the plaster, into which button a spreader, forked at each end, so as to button into the plaster. Having the two prongs to button into the plaster prevents the plaster from wrinkling and making sores on the leg. To this attach a cord with from fifteen to eighteen pounds in the adult. Excessive weight will defeat the purpose for which it is applied, by causing muscular spasm, and affords great discomfort to the patient.

Next have the sand bags ready—one 5½ inches in diameter by 4 feet in length, and another 5½ inches by 3 feet in length. Two smaller sand bags, each 4 inches in diameter by 2 feet in length, and one small sand bag 5 inches wide, 3 inches thick, and 10 inches long. Have an assistant grasp the ankle and make traction while the surgeon places his hand behind the trochanter major. While the assistant gently rotates the foot and leg inward, the surgeon